Hustisford School District

District Office
845 S. Lake St. · P.O. Box 326
Hustisford, WI 53034
(920) 349-8109

Jr./Sr. High School
845 S. Lake St. · P.O. Box 326
Hustisford, WI 53034
(920) 349-3261

John Hustis Elementary
600 S. Hustis. St · P.O. Box 326
Hustisford, WI 53034
(920) 349-3228

Todd Bugnacki
District Administrator

Clint Bushey
Principal

Peter Moe
Principal

Corey Manlick
Director of Financial Services

Alex Pishler
Director of Special Education/Psychologist

Glen Falkenthal
Athletic Director

Allergy Treatment & Emergency Plan

Student Name:_____ **Grade/Class**:_____ **DOB**: _____ **Allergy**: _____

My student also has asthma: ☐ Yes ☐ No **My student may self-carry & administer EpiPen**: ☐ Yes ☐ No

Epinephrine: ☐ EpiPen ☐ Epipen Junior **Antihistamine:** ☐ Benadryl_____mg ☐ Other_____

I authorize that this medication be administered at school, potentially by non-medically trained personnel.

- I will supply medication in its original, updated, properly labeled container.
- I will obtain a new physician's order and notify the school in writing for any changes.
- I authorize the school to exchange information with my child's provider re: this medication/condition for which it's prescribed.
- I understand the parent/guardian/responsible adult should deliver all medication to the school.
- I understand that this consent is in effect for the current school year (may include summer school).
- I consent that this treatment be provided during school hours, at after hours school sponsored events & on field trips.
- I consent to the release of the information contained in this Allergy Plan to staff members who may need to know this information to maintain my child's health and safety.
- I agree to hold the School District, its employees and agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication at school.
- My signature indicates that I have fully read and understand the above information.

AT THE END OF THE SCHOOL YEAR, PLEASE (circle one):

Contact me to pick up remaining medication	Dispose of remaining medication	Send remaining medication home with my student

My student has been instructed in Epipen use and is competent to self-carry & administer in school ☐ Yes ☐ No

Name of Provider: _____ Provider Phone Number: _____

Signature of Parent/Guardian: _____ Date: _____

TO BE COMPLETED BY THE PROVIDER: *The above medication is to be administered/performed during the school day in accordance with the above instructions. I agree to accept communication about student/medication/procedure and understand medication may be given by non-*

medically trained school personnel. **Student has been instructed in use of Epipen and is competent to self-carry & self-administer in school ☐ Yes ☐ No**

Provider Signature: _____ Date: _____